of medical interpreting services are provided per month in the Washington, DC, area alone (J Bailey, president of Sign Language Associates, Inc, Washington, DC, oral communication, July 1999). Would it be more cost-effective if a physician were able to communicate with deaf patients directly, even if it meant paying for interpreter services during that particular physician's training? Deaf people have told me alarming stories of repeatedly asking that an interpreter be provided at their doctor's office, only to have physicians turn down their request.

Physicians all owe an economic debt to the American public. Teaching hospitals are given substantial government funding for each resident trained. For the help in financing their education and training, physicians also owe a debt of gratitude. I have a deeply felt sense of duty and obligation because I am aware of the additional investment that was made on my behalf, and I am honored to share the outcome of that investment with my patients.

Economic issues aside, is it practical for patients to be seen by a deaf physician? Will the communication barrier compromise their quality of care? These are fair questions and should be addressed on an individual basis during the evaluation and screening process for admission to medical school.

Although I cannot answer for every person with a disability, I can answer for my own situation. I picked a specialty I felt was compatible with my disability. Dermatology is a visual field, and I am in my element when relying on visual information and available environmental cues. As for my level of patient care, as yet, I have received no complaints. Ironically, my patients tell me that they feel I truly "listen" to them. This is probably because I must look patients directly in the face while lipreading, and I attend to every word they say.

When I introduce myself to my patients, I explain my deafness and how we can communicate effectively. Patients, who are, by definition, vulnerable in some way, understand my vulnerability. Some patients feel that in their difficult times, it is easier to relate to a physician who is not "perfect."

The greatest opposition that I have faced has been from colleagues rather than patients. Some have told me outright that I would not be able to become a doctor, whereas others have openly expressed their desire to keep me in certain specialties so that my contact with the public will be diminished. None of these opinions suppressed my desire; rather, they have made me that much more determined.

I would want for each disabled person the opportunity that I had: to prove myself worthy, to be given the chance to measure up to the standards that others had to meet, and on meeting those standards, to be allowed to participate in life and society in the most fulfilling way possible. For me, this has meant being able to become a doctor.

I do not advocate the wholesale scrapping of standards to provide accommodation; however, the contribution of those standards to the process as a whole should be evaluated. I would not ask for accommodation so that I could be given training in, for example, piano tuning. Although this may be a possible achievement, it would be neither a prudent investment nor the best for people wanting their pianos tuned. Does every doctor have to be able to hear their patients to treat illnesses effectively? In my case, apparently not. But if I had to pay for the cost of accommodations myself, I may never have been able to complete my training.

Let people with disabilities figure out what they can do. Give them the chance to be pioneers, to guide their own futures. The UCLA medical school saw enough potential in me to give me that first chance, and Oregon Health Sciences University has built on that by accepting me into their residency program. I am eternally grateful to both institutions.

As a deaf woman, I am so thankful for the opportunities afforded me. I am aware of the sacrifice that others made that contributed to my success. If tomorrow someone offered me the ability to hear perfectly, but in exchange for my career, I would never accept. I am humbled and honored to be able to give of myself. In the words of Dag Hammarskjöld, I am finding "the humility that comes from others having faith in you."

At the time this was written, Dr Woolf was a third-year resident in dermatology at the Oregon Health Sciences University, Portland.

Lisa Woolf

Oregon Health Sciences University
Department of Dermatology
3181 SW Sam Jackson Park Road
Portland, OR 97201

Correspondence to:
Dr Woolf
Woolfl@ohsu.edu

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From "doctor" to physician

"If you could be anything you wanted to be, what would you be?" My father's query startled me. A year before, I had decided on a career in the Peace Corps and had dreamed of working long and harsh hours in remote lands with like-minded souls. I had just learned that Peace Corps stints (at that time) were of 2 years' duration, with one or two possible renewals. I had become morbidly depressed as only a 13-year-old can become at shattered dreams. Still, my response was quick, as if by instinct. "If I was a guy, I'd be a doctor. An orthopedic surgeon." If the reply surprised my father, he never let on. "So you're not a guy. So what?"

From that day on, I planned for a medical career. I would have all the bones in the body memorized before beginning college courses

in biology. Summer volunteer work and hospital employment only furthered my zeal. I graduated from high school in 3 years so as to get going on the goal I had set before me.

Thirty-two years after that brief conversation with my father, I am applying to medical schools. Despite my best-laid plans, bone memorization schedules, and unabashed enthusiasm, my academic life took a different direction. I became a "Dr," but one of philosophy. I received a PhD degree in the field of ancient Near Eastern history and culture, tackling, instead of bones, Sumerian and Akkadian, our first written languages dating from 3000 to 500 BC. Rather than tending to people's bodies, I worked with the intellect, teaching for 14 years as a university professor. For many years, I also taught night courses at the University of California at Los Angeles, where several of my students were physicians who eagerly read ancient history—stories written by Egyptians, Greeks, and Romans and the philosophical treatises of the Stoics. Many expressed their "envy" that I earned my keep by reading and writing. It was clear that these physicians yearned for an intellectual dimension their medical lives lacked, just as surely as I slowly sensed the absence of science in my own life. I never regretted my decision to become a scholar of ancient languages and history, but medicine continued to beckon me.

So it was, at age 43, I decided once again on a career in medicine. I had to start from scratch, teaching myself elementary algebra during my final semester of teaching at Reed College, Portland, Oregon, in preparation for the science program I had enrolled in. Finally, I was studying the college courses I had missed 25 years previously. A number of my classmates were former Reed students of mine. Students whose essays on the Old Testament, Homer, and Plato I had critically evaluated were now laboratory partners in physics and tutored me in organic chemistry. Science students tend to be more technicians than intellectuals, and I would notice that whenever my organic chemistry professor provided a brief historical excursion on a topic, pens suddenly ceased their furious note-taking. When studying for exams, I often heard comments like, "He just told us that stuff to give us a break." On those occasions, I was not always successful at holding my tongue. But I had the zeal of a convert. I needed it. To maintain the grades to remain a viable medical school applicant, I needed to call on all the mental reserves I could muster.

But had I simply romanticized medicine? I needed to find out, so I began a volunteer job in a cardiology wing at a sizable Portland hospital 3 days a week, apprehensive of what I would discover both there and within myself. To my surprise, within a few days, I felt completely at home. Many years of speaking with students and colleagues made conversing with patients and their families natural and easy.

Students whose essays on the Old Testament, Homer, and Plato I had critically valuated were now laboratory partners in physics

My volunteer coat, I found, signals my volunteer status only to nurses and physicians. Often when I have been assisting younger nurses, a distressed patient has turned to me, obviously seeking refuge in the "medic" with silver streaks in her hair, asking me if everything would be all right, or, in a couple of cases, if the nurse was doing the right thing. One of my greatest weaknesses, in fact, is to befriend patients. A cardiologist, a close friend of mine, has warned me about getting too involved with patients, knowing the difficulty such friendships might cause later on when my time is no longer my own.

I tend to think too much. But my life as a historian has made me sensitive to relations between people, and I have instinctively paused to observe how nurses, physicians, and residents react to each other and to patients. Physicians who have been on the ward for a long time often enjoy a warm relationship with staff. But I am amazed and occasionally appalled by the immaturity of some interns and residents. They show the same fear I remember so well of college students who desperately tried to appear at home in their new intellectual environment. In trying to shrug off their discomfort, they will assume a diffidence, an unconscious striving to look "cool" and "in charge"—even when it is neither called for nor possible. It has been painful at times to see the dismissive manner some residents display toward seasoned nurses and volunteers. I have often wondered if I am simply envious that such distressingly young looking men and women, some who could be my sons and daughters, have completed a medical education I covet. But I have also had the experience of a number of patients who, again not recognizing the volunteer jacket, have turned to me for an explanation—as if I could give one—of medical jargon an intern has just used in conversation with them.

I have been generally gratified by the warm reception by physicians, nurses, and staff if they know of my plans. One cardiologist, whose research project I had been asked to assist with and who had been told of my career change, exclaimed with a wide grin on meeting me, "I don't know whether to admire you or revile you!" The words were ambiguous, but the grin was obvious encouragement. Of course, it is easy to champion the underdog, but the sincere enthusiasm I have received augurs well.

I admit to envying my younger premed cohorts their stronger science backgrounds and, for many, their having grown up in an environment where science is bred in the bone. But, on the eve of several medical school interviews, I am confident that my years spent wrangling with ancient and arcane languages have brought many advantages. *Exempli gratia*, I already know that Latin bone terms are no obstacle.

Since writing this article, the author has been accepted to medical school and will begin her training in the coming academic year.

Sara J Denning-Bolle

3507 SW Jerald Court
Portland, OR 97221-4045

Correspondence to: Sdenning@easystreet.com

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